CHIROPRACTORS

PROVIDER CLASS PLAN

Provider Class Analysis
December 13, 1996

CHIROPRACTORS PROVIDER CLASS PLAN

I. COST

A. COST GOAL

The cost goal as specified under Public Act (P.A.) 350, states that, "Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." The goal is derived through the following formula:

$$\left(\frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

Where "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where "REG" means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

B. COST OBJECTIVES

1) To strive toward limiting the increase in total Chiropractor (D.C.) payments per member to the compound rate of inflation and real economic growth as specified in Public Act 350, giving consideration to Michigan and national health care market conditions.

2) To provide equitable reimbursement to D.C.s in return for high quality services which are medically necessary and delivered to Blue Cross and Blue Shield of Michigan (BCBSM) subscribers at a reasonable cost.

3) Each year retrospective profiles are made available to providers upon request.

I. COST

B. COST OBJECTIVES (cont'd)

4) BCBSM makes a good faith effort to enforce the per case participation rule in Section 502(1)(b) of P.A. 350 through its audit activities, its provider inquiry and provider consultant activities, and through responses to all complaints. BCBSM will annually report its efforts to enforce the rule and identify any violations that have occurred.

C. COST INITIATIVES

1) Reimbursement Policies

Blue Cross and Blue Shield of Michigan strives to limit increases in total D.C. payments per member while, at the same time, providing equitable reimbursement to D.C.s for medically necessary services by instituting the reimbursement policies described herein.

Blue Cross and Blue Shield of Michigan reimburses participating D.C.s for covered services which are deemed medically necessary by BCBSM. Determination of medical necessity is described in Addendum A and in accordance with the Contract Advisory Committee Process found in Addendum D of the attached Physician and Professional Provider Participation Agreement.

Reimbursement Method

For each covered service performed, BCBSM will pay the lesser of the billed charge or the published maximum screen as set forth in BCBSM's Maximum Payment Schedule. Addendum B of the Physician and Professional Provider Participation Agreement further describes the reimbursement methodology.

Billed Charge

The billed charge refers to the actual charge indicated on the claim form submitted by the provider.

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I. COST

C. 1) Reimbursement Policies (cont'd)

Maximum Payment Schedule

The Maximum Payment Schedule is based on Medicare's resource based relative value scale (RBRVS), a schedule of relative procedure values which reflect the resource cost required to perform each service.

The resource costs of the RBRVS system include provider time, specialty training, malpractice premiums, and practice overhead. Values are assigned to each service in relation to the comparative value of all other services. The overall payment level under the RBRVS system is established through the conversion factor. A BCBSM-specific conversion factor is used to determine payment levels under the RBRVS system.

There is currently one maximum payment schedule. BCBSM will give individual consideration to cases involving complex treatment or unusual clinical circumstances in determining a payment level which exceeds the maximum reimbursement level.

An alternative reimbursement arrangement is available to groups through the Medical Surgical (MS-90) program. The MS-90 program was designed to increase reimbursement levels for purposes of reducing out of pocket payments in regions where participation rates were low.

2) Participation

Chiropractors may choose to participate on either a formal or per case basis with BCBSM. Formally participating providers agree to accept BCBSM payment as payment in full for all services provided to BCBSM members. Chiropractors participating on a per case basis must accept BCBSM payment as payment in full "for all cases involving the procedure specified, for the duration of the calendar year". [Michigan Public Act 350, Section 502(1)(b)]

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I. COST

C. 3) Utilization Management Programs

Blue Cross and Blue Shield of Michigan strives to ensure that only medically necessary services are delivered to subscribers through the implementation of utilization management programs.

4) Appeals Process

An appeals process has been established whereby participating D.C.s have the right to appeal policy and non-policy issues made by BCBSM. This process is described in Addendum E of the Physician and Professional Provider Participation Agreement.

II. ACCESS

A. ACCESS GOAL

The access goal, as specified under P.A. 350, states that, "There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

B. ACCESS OBJECTIVES

1) To ensure adequate availability of high quality medical services, throughout the state, at a reasonable cost to BCBSM subscribers.

2) Maintain a reimbursement methodology in accordance with the Physician and Professional Provider Participation Agreement that is based on the lesser of billed charges or BCBSM's maximum payment schedule.

3) BCBSM will review reimbursement levels at least every 12 months.

   An alternative reimbursement arrangement is available to groups through the Medical Surgical (MS-90) program. The MS-90 program was designed to increase reimbursement levels for purposes of reducing out of pocket payments in regions where participation rates were low.

4) Maintain and periodically update the directory of participating physicians and professional providers.

5) Maintain and update, as necessary, in the physician'smanual a "Providers' Bill of Rights" explaining: (1) a provider's right to a managerial level conference under P.A. 350; (2) how the managerial levelconference process works and the timeframes involved under it; (3) when the P.A. 350 process can be invoked; (4) how this process relates to the other processes described in the contract. This communication will emphasize that a managerial level conference is a right guaranteed by law to every provider and that arbitration is an alternative to this right.

II. ACCESS

C. ACCESS INITIATIVES

1) Formal Participation

The new Physician and Professional Provider Participation Agreement is designed to increase the number of formally participating D.C.s in selected areas and to improve BCBSM relationships with providers.

2) Per Case Participation

Participation for the D.C. Provider Class is also allowed on a per case basis for chiropractors not formally participating with BCBSM. Chiropractors who participate on a per case basis will be monitored to ensure that acceptable standards of professional performance which apply to formally participating D.C.s are also met for the per case participants.

3) Hold Harmless Provisions

The Physician and Professional Provider Participation Agreement establishes guidelines that hold BCBS subscribers harmless from:

- balance billing;
- liability for non-medically necessary services; and,
- financial obligation for covered services provided but not billed to BCBSM within a reasonable period

except under those circumstances outlined in Addendum F of the Physician and Professional Provider Participation Agreement.

4) Utilization Management and Quality Assessment

BCBSM strives to reimburse for medically necessary services at a reasonable cost to its members through implementation of the utilization management and quality assessment programs which are described in the Cost and Quality sections of this plan.

II. QUALITY OF CARE

A. QUALITY OF CARE GOAL

The quality of care goal as specified under P.A. 350, states that "Providers will meet and abide by reasonable standards of health care quality."

B. QUALITY OF CARE OBJECTIVES

1) To ensure the provision of quality care to BCBSM subscribers through the application of participation qualifications and performance standards as a basis for D.C. participation.

2) The Physician and Professional Provider Contract Advisory Committee meets on an ongoing basis, generally at least quarterly, to offer advice and consultation on topics such as: proposed modifications to the contract; administrative issues which may arise under the contract; medical necessity criteria and guidelines; reimbursement issues; experimental or investigational procedures; and physician supervision of services.

3) Work with the Physician and Professional Provider Contract Advisory Committee to develop medical necessity criteria, as necessary.

4) The Chiropractor's Manual will be revised, maintained, and updated to explain billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements and an explanation of the Physician and Professional Provider Agreement and its administration.

5) Protocols and procedures relating to BCBSM's Physician Retrospective Profiling Program will be communicated to providers as they become available.

II. QUALITY OF CARE

C. QUALITY OF CARE INITIATIVES

1) Qualification Standards for BCBSM Participation

Blue Cross and Blue Shield of Michigan offers all qualified D.C.s the opportunity to participate. In order to participate with BCBSM a D.C. must be licensed by the State of Michigan Department of Licensing and Regulation. Licensure status is continually reviewed to ensure that participation requirements are appropriately maintained.

2) Quality Assessment

Formal and per case participation for D.C.s is contingent upon BCBSM's acceptance of qualifications and professional standards. These standards may include, but are not limited to:

- o satisfaction of licensure;
- o absence of inappropriate utilization/medical necessity practices as identified through proven subscriber complaints, medical necessity audits and peer review; and,
- o absence of fraud and illegal activities.

3) Departicipation Policy

A departicipation policy has been established that provides for review and recommendation for departicipation by the BCBSM Audits and Investigations Subcommittee (AIS). This policy is further described in Addendum I of the attached Physician and Professional Provider Participation Agreement.

4) Appeals of BCBSM Reviews

An appeals process has been established whereby participating D.C.s have the right to appeal policy or non-policy issues made by BCBSM. This process is described in Addendum E of the Physician and Professional Provider Participation Agreement.

IV. OTHER

A. OTHER OBJECTIVES

1) To facilitate administration of the Physician and Professional Provider Participation Agreement, BCBSM will continue to discuss issues regarding the Agreement with the Insurance Bureau upon request.

2) BCBSM will not apply any sanction to subscribers receiving services from departicipated providers unless it is authorized to do so by an amendment to P.A. 350 or other appropriate authority.

V. PHYSICIAN AND PROFESSIONAL PROVIDER PARTICIPATION AGREEMENT (Attached)